Department of Medical Assistance Services
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www.dmas.virginia.gov

MEDICAID MEMO

TO: All Providers of Developmental Disabilities (DD) Waiver Services, Support Coordination/Case Management services, EPSDT Private Duty Nursing, and EPSDT Personal/Attendant Care Services.

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 9/8/2017

SUBJECT: Delay in Implementation of Early Periodic Screening and Diagnostic Treatment (EPSDT) Service Authorizations in Developmental Disabilities (DD) Waivers

The purpose of this memorandum is to notify providers of a delay in the implementation of processing requests for Private Duty Nursing and Personal Care services for individuals in Developmental Disabilities (DD) Waivers under the age of 21 through the EPSDT benefit. Memorandums dated June 30, 2017 and July 26, 2017 conveyed changes in the submission requirements for requests for EPSDT services, effective August 1, 2017, which would bring the services in compliance with the Centers for Medicare and Medicaid Services' (CMS) requirements that certain Medicaid funded services for individuals under the age of 21 be approved through the EPSDT benefit. These changes affect the three Waivers that serve individuals with DD: Community Living (CL), Building Independence (BI), and Family and Individual Supports (FIS).

In order to maintain continuity of care and give providers sufficient time to implement changes, DMAS is delaying the aforementioned changes to November 1, 2017. Prior to **November 1, 2017,** service authorization requests for personal care and private duty nursing will follow the previous submission requirements. The chart below illustrates the required documentation for service authorization requests for dates of service effective prior to November 1, 2017:

SERVICE	PROCEDURE CODE (CPT codes)	REQUIRED DOCUMENTATION
Personal Care	T1019 (agency directed)	• DMAS 97A/B, if a personal care agency with the DBHDS Personal Preferences Tool OR • Part V of the Individual Support Plan (ISP) if DBHDS licensed agency; and

		• Documentation submitted must include name of the person delivering the service and relationship to the individual.
	S5126 (consumer directed)	See above
Private Duty Nursing	T1002 (RN)	• The current CMS 485 Home Health Certification and Plan of Care with the DBHDS Personal Preferences Tool; • Part V of the ISP
	T1003 (LPN)	See above
	G0493 (Congregate RN)	See above
	G0494 (Congregate LPN)	See above

Authorization Requests Submitted on or after November 1, 2017

For services beginning ***on or after November 1, 2017***, services must follow the provided guidelines and documentation requirements articulated in the memorandums from June 30, 2017 and July 25, 2017.

SERVICE	**PROCEDURE CODE (CPT codes)**	**REQUIRED DOCUMENTATION *on or after November 1, 2017***
Personal Care	T1019 (agency directed)	• DMAS 7 EPSDT Personal Care Services Functional Status Assessment (must be updated every year); • DMAS 99 Community Based Care Recipient Assessment Report (must be updated every year); • DMAS 7A EPSDT Personal Care Program Agency and Consumer-Directed Plan of Care (must be updated every year); • Part V of the Individual Support Plan (ISP); and • Documentation submitted must include name of the person delivering the service and relationship to the individual.
	S5126 (consumer directed)	See above
Private Duty Nursing	T1002 (RN)	• DMAS 62 Medical Needs Assessment (to be updated and resubmitted every 6 months); • The current CMS 485 Home Health Certification and Plan of Care;

		• Part V of the ISP; and • Two weeks of nursing notes (for renewals only).
	T1003 (LPN)	See above
	G0493 (Congregate RN)	See above
	G0494 (Congregate LPN)	See above

All EPSDT PDN and Personal Care authorization requests for individuals on the DD Waivers should be submitted to DBHDS through the WaMS system, regardless of the service start date.

The DMAS-7 form for EPSDT Personal Care and/or DMAS-62 form for Private Duty Nursing should be completed and signed at least two weeks prior to the expiration date of the current authorization to avoid potential disruption of services. Completion of these forms are required with renewals or changes in the authorized levels (for example, increases in service hours). DMAS therefore strongly encourages providers to prioritize appointments with members seeking these service authorizations.

Note that the DMAS-7 form requires a signature from a Physician (MD or DO), Nurse Practitioner (NP), or Physician's Assistant (PA). The DMAS-62 must be signed by a Physician (MD or DO) only. For the purpose of the authorization, the healthcare professional signing these forms *does not* have to be a Virginia Medicaid enrolled provider.

Validation of Medical Necessity
The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization is specific to an individual, a provider, a service code, and established quantity of units, and for specific dates of service. Service authorization does not guarantee payment for the service.

Reimbursement Rates
There is no change in reimbursement rates.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)
Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS
Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to

a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus): http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

NEW MEDICARE CARD

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Until now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html